STATE PLAN FEEDBACK (third set)

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
General Comments				
This is a short note to state our support of the documents coming from the State Collaborative regarding the children's mental health portions of the most recent State Plan draft. The Mental Health Association in North Carolina has been involved in the State Collaborative since it's beginning. We wholeheartedly support the recommendations and language developed by the State Collaborative for the next Draft of the Plan. We believe that these recommendations are in the best interests of the development of a statewide system of care for children and everyone involved.	❖		Low	Comment from State Collaborative
Today in the State Collaborative the group came to a consensus that to focus only on the very high end kids and families in the mental health plan defeated the core meaning of the System of Care philosophy. Prevention and early intervention is an intrinsic part of any family friendly system of care. To limit the target population to the most sever is to cause families and children with emotional, behavioral and mental health challenges to suffer needlessly. The whole point is to prevent children from needing the high-end services and supporting families. The State Collaborative supports the broader target population definition in the state plan and encourages that we as a state move towards the System of Care model. Put SOC back into the state plan.	❖		Medium	Target population covers severe, moderate and mild mental health problems. System of Care (SOC) philosophy described under Child Mental Health Services in main document. Prevention and early intervention supported by mission and principles of state plan.
There should be enough providers to actually allow for not only quality providers but quality choice.	❖		High	Supports state plan vision. LME business plans are to address issue.

GENERAL COMMENTS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
General Comments				
Compliance should be a state function where as monitoring should be a local function.	❖		Medium	Refer to document entitled "Requirements of a Local Business Plan."
Many consumers/families /advocates have complained about difficulty in getting the plan, getting notice of the forums, etc. Based on the reading of the plan opportunities were provided for these groups to participate in this planning process. There is concern that there is not true public feedback to the plan. There is perception that the State is developing a plan, with only input from the State, and the communities are going to have to live with it.	❖		High	The State Plan calls for state and local consumer and family advisory committees as described on page 38 in the main document. State Plan establishes an Office of Consumer Affairs by 7-1-02.
There is a feeling the state plan describes many cutting edge ideas and concepts, but at the same time keeps our state firmly entrenched in the previous century with one ongoing commitment to the outdated institutional model.	❖		High	See implementation schedule.
There is a feeling there needs to be greater substance in the state plan, there needs to be less volume and prettiness. The reader doesn't need to be dazzled, just give them substance they need to read.	❖		Medium	State plan is comprehensive enough to articulate a commitment to service and system accountability at the state and local level.
A general sentiment is that it took a long time to develop this document – and a short period for consumers, advocates, providers to read, discuss, comprehend and comment is simply not adequate nor reasonable.	❖		High	From the beginning the HHS Secretary has met with consumer and family members and advocates to hear their concerns, listen to their suggestions and to consider their recommendations. The plan creates a new mechanism to ensure ongoing consumer and family involvement and oversight.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Access				
There is a concern that it is impossible to determine DD needs through phone interview.	❖		Medium	Phone interviews are designed to enhance access. Initial screenings can be done face to face, as well.
There is concern with the allowance of poor quality staff to become accredited and directly enrolled. The state should not allow a provider to enroll without some knowledge of his or her practice.	❖		Medium	Supported in state plan document.
There is concern that very few providers are willing to hang on to "difficult" clients.	❖		High	Supported in the main document of the state plan.
The competency based employment system that is used for individuals that from the statewide registry is supported.	❖		Medium	The state plan supports a competency-based system consistent with national movement.
We need to find away that early in the assessment process a person could be supportive in identifying and developing natural supports that could assist the provider in fulfilling the needs of other provider.	❖		Medium	The new service system supports participant driven process.
The general draft fails to acknowledge the terrible demoralization and disarray of the MH/DD/SA workforce. This plan should offer and aggressive and comprehensive plan to recruit and retain the most talented professionals in public sector.	❖		High	Note material presented in document entitled "Staff Competencies, Education and Training."
There is a great concern over the need for a unified complaint system that needs to be placed in rule to conform to the reform bills requirements upon the Secretary to enforce the protection of rights of clients.	❖		Medium	The Reform Bill and the State Plan calls for the HHS Secretary to study the value of consolidating various programs and report to the LOC by 3-1-02.
There is great concern on the strong outreach component to access. Shifting the burden from the person finding the services to finding the people needing services.	❖		High	Uniform portal supports the concept of "no wrong door" into service system, along with multiple access points. Outreach both at system and client specific level are to be described by LME in their local business plan.

ACCESS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
Expressed concern regarding how the system would respond to those with experiencing psychiatric crisis.	❖		Low	Covered in core services.
Children of persons with MH/DD/SA should be a priority for the redesign for our MH/DD system. It is thought that by having a parent/parents whom deal with these issues puts the child at greater risk for problems down the road.	❖		Medium	Addressed in main document of the State Plan.
While it is agreed that individuals who have the greatest need should be served first, inadequate resources will cause our waiting list for DD services to grow, lower level needs will eventually turn into crisis if services are not obtained and this can result in lawsuits.	❖		High	Supported in the state plan vision in the main document.
It was thought that it had been agreed upon to add individuals with SMI who are risk for functional disabilities to the target population. Otherwise you will exclude people who are doing well but need treatment to advert disability.	❖		Low	See Adult Mental Health target population the section on co-occurring disorders in the main document
There is concern that the SA section of the plan places little emphasis on integrated MH/SA treatment and fails to recognize the dually diagnosed as a target population.	❖		Medium	Co-occurring disorder included in plan on page 25 of main document. Sub-committee on co-occurring disorders will continue to address these issues as implementation plan proceeds.
There is concern about persons with disabilities who also have mental health or substance abuse problems.	❖		Low	Addressed in co-occurring disorders section in the State Plan.
There is a question whether Medicaid populations are entitling population's figures into the populations that will and will not be served.?	❖		Medium	See section on "Target Populations and Department/Division Coordination and Infrastructure" in the main document
Material presented on Target Populations by DD was consistent with Arc.	❖		Low	See description of target population in main document.
DD/SA and at risk children are all appropriate for the target populations, however there are not very tight	❖		Medium	Eligibility criteria tighten

TARGET POPULATIONS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
limitations. This means there will always be a greater demand for services than there are resources available.				
It is expressed that it would be helpful to see the entire plan in same format.	❖		Low	Formatted in final draft document.
Resource allocation should be directly related to service priorities. There needs to be an association between money and need.	❖		Low	See implementation plan with due dates of 3/1/02, 5/1/02, 7/1/03 and 1/1/07.
Target populations set forth, support values of our system.	❖		High	See main state plan document.
At a minimum any citizen who request services and referral should be given that opportunity.	❖		High	See core functions and access issues.
True reform would place more emphasis on prevention and early intervention efforts.	❖		Low	See state plan mission.
There is certainly a need to provide services for those with SPMI, Chronic Substance Abuse and persons with Developmental Disabilities.	❖		Medium	See target population in main document.
Persons who would be capable of being served in private sector should do so.	❖		Medium	See main document and document entitled "Requirements of a Local Business. Plan."
When Persons who are currently receiving services, no longer meet eligibility requirements. We should either complete their treatment or make an appropriate referral to another provider.	❖		High	See "Core Functions and Access Issues" in the main document.
Private Sector should have an equal opportunity to serve our target populations and they should place specific emphasis on the difficult to serve as well as the creating of prevention programs.	❖		Medium	See "Programs and Qualified Providers" in the main document.
If there are to be controls over the amount of services provided, there must be clear measurable criteria, which can be fairly and consistently implemented.	❖		Low	See "Staff Competencies" in the main document.
The urgency of need chart as presented, will not adequately reflect needs of many people who are waiting for DD services.	❖		Low	See "Target Populations" and "Developmental Disabilities" in the main document.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
It is going to be difficult to differentiate between urgent and critical as currently presented in the chart. There needs to be a scale to assist with this condition.	❖		Low	See "Target Populations" in the main document.
Crisis services should be individualized according to needs of the person.	❖		Low	See Crisis Services under the section entitled "Local Management Entities."
If a person no longer meets service criteria, an assessment should be made as to whether the person is service dependent before they can be discharged from services.	❖		Medium	See Chapter Three in the main document.
Private providers should work collaboratively at the local level to ensure services are available to consumers in all geographic areas.	❖		Medium	Services are delivered by privates and they are to be involved at LME – see business plan
Private providers should provide services in accordance with state requirements and self monitor to ensure quality of services.	❖		Low	See requirements of a Local Business Plan in the main document and in the document entitled "Requirements of a Local Business Plan."
Private providers should complete services in accordance with individuals treatment plan and participate in satisfaction surveys, outcomes assessments, utilization management and other monitoring activities.	❖		High	See requirements of a Local Business Plan in the main document and in the document entitled "Requirements of a Local Business Plan."
Private providers should provide incident reporting data as required.	❖		Low	See document entitled "Quality Management."
Local public agency should provide a continuum of case management and system management functions.	❖		High	See section entitled "Duties and Functions of LME" in the main document.
Target population is about making tough choices, adult MI has done better than any other disability group at making there choices.	❖		Low	See "Target Population" in main document.
Those individuals experiencing episodic illness, but not experiencing interference of function would not receive services.	❖		Medium	State resources will be targeted for target population. Limited benefit package for non - target.
We have an obligation to the client to provide service for as long as he or she wants this service.	❖		Low	There have to be clear limits to the amount of service a client receives as long as the client is

TARGET POPULATIONS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
				functioning well.
Target populations have the right to service, whether Medicaid eligible or not.	❖		Medium	See "Target Population" in the main document.
Role of the private sector should be greatly expanded. One of the problems of the current system is we have not encouraged for development of private providers which has decreased access and choice for the customer.	❖		Medium	See section entitled "Area Programs and Qualified Providers" in the main document.
State and local programs are going to have to totally retool to encourage the growth and development of provider networks and providers.	❖		Low	See main document and document entitled "Requirements of a Local Business Plan."
Target populations need to put more emphasis on prevention, as it needs to play an important role.	❖		Low	Prevention is a macro core services and supported by mission statement.
Resources should be allocated based on the potential to add value to ones life.	❖		Low	Person centered supports
For those with little hope of improvement we owe the provisions of a safe custodial environment.	❖		Low	Long term care for all disabilities and benefit package is not all medically driven.
We must be willing to stop the provision of services for those persons who are no longer eligible without putting them in danger.	❖		Low	See section on "Transition" in main document
The use of public dollars means the public should decide on priority population and public agencies should assess needs not private providers.	❖		Low	LME will manage designated access points.
There is a concern that there is so much talk about change, without movement toward it.	❖		Medium	See "Challenges of Change" in the main document.
We should meet the lowest level in the hierarchy of needs for all populations. This means concentrating on psychological and safety before focusing on higher needs.	❖		Low	See "Core Services" in the main document.
The ultimate goal of self-actualization would be based on the dependability of natural resources.	❖		Low	See state plan mission statement.
If we are to have a true state plan, then we need to	❖		Medium	See "Strategic Plan" in the main document.

TARGET POPULATIONS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
identify all needs that would fall under MH/DD umbrella. Then it must be determined which needs would be served under each of the three sectors; federal, state or private.				
The state plan must first identify total needs and then break down consumers by target groups within the areas of need.	❖		Medium	See guiding principles in the main document.
There is support of the definition of DD as defined in GS122C-3 as target population.	❖		Low	See section entitled "Developmental Disabilities" section in main document.
Those who meet the definition of DD and who are in need of assistance to live in communities of their choice, should receive services.	❖		Medium	See section entitled "Developmental Disabilities" section in main document.
Those who don't meet definition or are not in need of service should be discontinued in a thoughtful manner that maintains the health and safety of each person.	❖		High	See section entitled "Developmental Disabilities" section in main document.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Array of Services/Service Gaps				
There is a concern that DD services is being molded into a model, that is appropriate for MI/SA/	❖		High	Services are consistent with the mission/vision/principles of the State Plan.
If we are planning to reduce the role of the MR Centers in providing the residential support. Then it is important to address how care will be funded in the community.	❖		High	Funding continues to be developed in the implementation plan that will follow the person upon discharge from state facilities. Two pilot projects are targeted for 7-2-02.
There is a concern that all license professionals counselors will be able to serve all people in the public has more choice in determining who serves them.	❖		High	See "Staff Competencies and Qualified Providers" in the main document.
There is a perception that the system of care is a wonder drug when in reality it is a placebo.	❖		Low	See "Access Issues" in the main document.
A truly reformed system needs to pay more significance attention to clarify eligibility, finding and treatment policies as well as he very real problems of overlaps and gaps in coverage between mental health, Medicaid and social services policies.	❖		Medium	See "Core Functions" and "Requirements of the LME" in the main document.
The balance approach to residential care for persons with DD is applauded. It is important that state MR centers continue to downsize while still maintaining their availability to provide regional support to the LME's.	❖		Medium	See section on DD Services in the main document.
Too many children are ending up at state psychiatric hospitals being served by providers who say they don't know how to provide services to folks with DD.	❖		Medium	See section on DD Services in the main document.
The service gaps identified do not appear consistent with what is identified as services provided in the state plan.	❖		Low	See section on DD Services in the main document.
It is thought that MR/MI units will be relatively useless with the limitation of providing services to persons with moderate/service retardation. Effectively excluding persons with mild MR/MI to be served.	❖		Medium	See section on DD Services in the main document.
Giving parents the option to go out and obtain the	❖		Medium	See "Designing a New Service System" in the

ARRAY OF SERVICES

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Array of Services/Service Gaps				
services they feel are most beneficial adds the important dimension of self-determination to the equation.				main document.
There is a concern among psychiatrist that the state plan as written precludes the ability to provide services at the mental health center.	❖		Medium	Reform bill calls for a change of LMEs as providers of services to managing services. Plan calls for LMEs to consider development of full service one-stop settings.
There is some sentiment that in certain situations it is vital that case managers and clinicians work closely together to insure the highest quality of services.	❖		High	See "Staff Competencies and Qualified Providers" in the main document.
There is a great concern among clinicians that it if the system makes it hard for individuals to maintain care they will relapse much more than often.	❖		Medium	See "Target Population" in the main document.
Limiting the number of units of service a client receives is only a good idea if professionals who deliver the highest quality of services are providing the services. There is a great concern that in certain areas of the state it will be very difficult to recruit and retain the level of clinicians that are needed to provide the highest quality of care.	❖		Medium	See "Department/Division Coordination and Infrastructure" in the main document.
There is concern that mandated separation of services is going to destroy the continuity of care, decrease quality of care and increase barriers to interdisciplinary communication.	❖		High	See "Challenges of Change" in the main document.
There is concern that the system as proposed provides crisis driven acute care but not consumer driven care focused on prevention.	❖		Medium	The mission and principles support participant driven care and prevention programs.
Persons with multiple diagnosis could easily fall through the holes of the service delivery safety net and not receive needed supports in the community.	❖		Medium	State plan address co-occurring disorders.
It is widely thought that individuals have the right to services in there own communities where natural	❖		High	Supported in the mission statement and throughout the main document.

ARRAY OF SERVICES

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Array of Services/Service Gaps				
supports exist. People are fearful that they will be moved to regional facilities far away from their homes where these services don't exist.				
There is fear that our states Olmstead compliance might be challenged because of the lack of ability to move individuals into common based settings.	❖		Medium	Mental Health Trust Fund of $47.5 million will help to expand capacity and assist in the implementation of the Olmstead Plan.
There is a concern when downsizing and community settings are provided, with adequate provision in common be made for the hospital level care of children of DD.	❖		High	Supported in the mission statement and throughout the main document.
It is believed by some that the provider community struggles to provide services with less than adequate resources.	❖		Medium	See guiding principles and vision in the main document.
To assume the array of private services will automatically be developed is dangerous.	❖		High	An essential element of the local business plan will be the development of a qualified network and range of services.
A general concern was voiced that a greater emphasis needs to be placed on the provision of services for aging members of DD population.	❖		Low	Supported in item 88 in the implementation plan.
Tracking only new people does not present an accurate picture of who is being served because there are many people in advanced programs that are being served but not funded.	❖		Low	The plan recognizes the need to adjust to account for populations and service mix.
There is a concern that the state plan as it is now written represents a business approach and does not address the needs of clients nor quality of services.	❖		Medium	See mission statement in the main document.
There is a need for provision of care for children with DD after school hours until the parent/caretaker ends the workday.	❖		Low	See section entitled "Work, School, Activity and Leisure" in the main document.
There would be more Medicaid client's seen, if it were known that the mental health system would provide psychiatric back up for these people.	❖		Low	See document entitled "Requirements of a Local Business Plan."

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Array of Services/Service Gaps				
There is great concern for providing funds to reimburse consumers and family members for basic costs such as transportation, room and board so that active and consistent participation is possible.	❖		Medium	See section entitled "Array of Services for Target Population."
There needs to be consideration for a mentoring system which pairs a consumer and/ or family members with a advocate who can offer support to them in early stages of their participation.	❖		Medium	See section entitled "State and Local Consumer and and Family Advisory Group" and the document entitled "Consumer and Family Involvement."
There is concern that the relationship between the Department of Public Instruction and the community collaborative remaining ambiguous. There are many questions concerning DPI funds and if they are a part of the "braided funding".	❖		Low	See chapter entitled "Description of Current System" in the main document.
There seems to be concern over the issue of transitional services, meaning individuals going from children services and programming to adult services and programming.	❖		Medium	See section entitled "LME's Evolving Role" in the main document.
It has been stated that we must build infrastructure in each community which will enable people to access Natural and generic supports, as not all supports an individual needs should be of paid or specialized nature if "community membership" is truly a goal of the system.	❖		Medium	See section entitled "Infrastructure" in the main document.
For individuals with DD, there is a need for self-determined supports to facilitate successful living in the community.	❖		High	See section in main document entitled "DD Services."
There needs to be recognition that many service providers actually want and enjoy working for area programs. They do not want to become entrepreneurs.	❖		High	See section on "Qualified Providers" in the main document.
A function of the LME is to insure the development and accessibility of an array of supports and services.	❖		High	See section on "LMEs" in the main document.

ARRAY OF SERVICES

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Array of Services/Service Gaps				
Another function is to provide consumers with adequate knowledge to make informed choices	❖		Medium	See section on "LMEs" in the main document.
The LME's act as a catalyst to promote fair competition	❖		Medium	See section on "LMEs" in the main document.
Timely reimbursement for services is very important.	❖		Medium	See section on "LMEs" in the main document.
There was a concern on Medicaid reimbursement. The concern centered on timely reimbursement for service contractors that had to turn in Medicaid number and bill AP. This leads to timely reimbursement.	❖		Low	See section on "LMEs" in the main document.
There was a request that the North Carolina Substance Professional Certification Board work with the workgroup on Privileging and Credentialing. It was felt there was an importance of becoming involved in this process quickly.	❖		Low	See section on staff competencies in the main document and the document entitled "Staff Competencies, Education and Training."
The use of best practice will improve how facilities function, but how will it work with individual and/or direct bill providers.	❖		High	See section on "Qualified Provider Network and Direct Enrollment."
For those facilities that have best practice standards we should make them reflect an awareness of those standards and how treatment, which is provided, relates to the standards.	❖		Medium	See section on "Housing and Residential Services" and "Licensing and Monitoring Services" in the main document.
There is a strong voice to be part of the provider network group. Community based providers are one the four major components of the system. The other three being Consumers, LME's and DHHS.	❖		Medium	See main state plan document.
Providers must show capabilities to ensure the provision of a wide capacity of integrated and coordinated services with clearly defined roles.	❖		Medium	See section entitled "Qualified Provider Network" in the main document.
Area programs need to provide interim services if there are no treatment planning services or funding available.	❖		High	See "Access Issues" and Array of Services" in the main document.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Array of Services/Service Gaps				
When a facility is licensed for five respite beds, there is a recommendation that four beds be licensed for respite and the fifth bed being licensed for crisis respite.	❖		Low	Not accepted because of high number of people waiting for residential placement.
There was recommendation that the system not be so silo based that we are unable to respond appropriately to the needs of the multiple diagnosed. In the best of all world's, teams would review the triage so that multiple needs would be recognized and addressed.	❖		Medium	See "Target Populations" and "Array of Services" in the main document.
There needs to be encouragement in using the concept of Case Rate vs. Billable Hours when thinking of patients with chronic conditions.	❖		Low	This is a funding decision. Case rates will be an option.
There is a concern about DD being separate entity from Mental Health/Substance Abuse.		*	Low	This issue has been discussed in other circles and the decision to keep combined is current
There was a concern on how the general public/business sector would be able to share their voices and impact on the State Plan.	❖		High	See main document.
There was a question raised on how communities will communicate and work with each other. There is a need to work with communities to see how they are going to respond to incidence of crisis.	❖		Medium	See "System Quality Domains" in the main document.
The services that were listed are all appropriate for people with mental illness. There is more than a transportation issue. It has to do with the nature of the emergencies that arise.	❖		Low	See section on wraparound services and supports in the main document.
There is a need for outreach based emergency services. In rural areas there is a need for a rotating call system of staff.	❖		Medium	See section entitled "Designing a New System for MH/DD/SAS"
We need to encourage the use of Ambulatory/Community services as opposed to using facilities for emergency services.	❖		Medium	See section entitled "Designing a New System for MH/DD/SAS"

ARRAY OF SERVICES

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Array of Services/Service Gaps				
People feel they are loosing a choice between public and private choices. There are a few advocates driving the mental health to a private system.	❖		High	See section entitled "Designing a New System for MH/DD/SAS"
There is a fear of loosing choice; quality and the right to appropriate treatment with providers of there own liking.	❖		High	See section entitled "Designing a New System for MH/DD/SAS"
Repair and rebuilding of our fragile area programs is necessary but their elimination is not desired.	❖		High	See section entitled "Designing a New System for MH/DD/SAS"

ARRAY OF SERVICES

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
There has been an inquiry concerning at what cost to the state, would setting up a system of uniform access come about.	❖		Medium	Will be an item in the implementation plan and must be implemented to accomplish mission.
The writers of the 1st draft have no right to dismantle services that the Mental Health Centers are providing. Citizens should be aloud to continue to receive services through the area programs.	❖		High	Mental Health Reform Bill calls for a reduction in the number of area programs, as well as a shift in the role of LMEs from providers to managers of services.
The plan appears to attempt to destroy working relationships with private providers while blaming them for driving up cost.	❖		High	State Plan recognizes the important role private providers currently play, as well as their significance in the new service system.
The over reliance on public facilities and the need for community based mission are missing from the plan as well as the need to address community capacity building in a meaningful way.	❖		High	Addressed in main document and in the implementation plan.
There is a belief that a bulk of our resources be used on client outcome evaluation efforts.	❖		Medium	See section entitled "Designing a New System for MH/DD/SAS"
There is a concern that the new system is just business as usual with fewer programs.	❖		High	The State Plan requires changes in practices, leadership methods, and business functions as described in the main document.
The Division is still seen to some as the "Ivory Tower" to some people.	❖		Low	See section entitled "Designing a New System for MH/DD/SAS"
There is a concern that even though all new material presented there is little that is different form current system.	❖		High	See section entitled "Designing a New System for MH/DD/SAS"
It is recommended that the state plan take a more specific approach to structuring the relationship between DMA in the Division, since Medicaid is the key function of the public system.	❖		Low	The plan addresses the cooperation necessary between DMA and the Division.
It is recommended in the state plan that Secretary appoints a deputy in the Division, who also serves as a deputy in DMA so that they will be able to foster a	❖		Low	See section entitled "Designing a New System for MH/DD/SAS" and "Implementation Plan" in the main document

IMPLEMENTATON

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
working relationship between the two divisions.				
There is a concern that the definition of service coordinators is inconsistent throughout the document. In places it looks like a macro function. It appears to be more akin to case management. A consistent definition is needed.	❖		Medium	Service coordination as a core service is described more as a macro function.
There is a general concern that many of the positive idea's presented in the plan will never come about because of extreme lack of funding that always seems to exist.	❖		High	The 2001 Legislative session established a trust fund that will help support the mission of the State Plan.
Concerns that the LME will be asked to take on added responsibility of monitoring provider competencies.	❖		Medium	See "Requirements of the LME" in the main document.
Because of Medicaid reimbursements are so low and because of the tendency for many Medicaid recipients not to show up for appointments many providers unwilling to see them.	❖		Medium	See "Area Programs and Qualified Provider Network" in the main document.
Why would a private psychiatrist be willing to accept Medicaid reimbursement have any desire to contract with LME? What is the point of the middleman?	❖		Medium	The plan addresses the role of direct enrollment and billing.
There is a concern that the DD population of NC, according to the plan appears only to address those able to receive Medicaid funding. We need to take steps to combine limited state funds with matching federal dollars.	❖		High	Additional steps will need to be taken to address matching federal dollars.
While the plan speaks of consistency, there is a great concern that little is being done to level out the inconsistencies with regards to quality of services throughout the state.	❖		High	The purpose of implementing a uniform access system is to level out the inconsistencies across the state.
Individual supports (one on one) are expensive and lack of funding has created a need for congregate	❖		Medium	The State Plan addresses this issue as it describes a participant-driven system that supports the

IMPLEMENTATON

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
settings.				individual and family in selecting services and supports.
There is a general concern that funding is an extremely low level that said, the current level must be maintained, if not increased, and the control of funding needs to be in the hands of people who benefit from the services.	❖		High	See "Designing a New System for MH/DD/SAS" in the main document
There is a belief that for most severely ill patients, the best coordinated treatment occurs when the providers regularly work together.	❖		Medium	The plan directs the LMEs to develop a qualified provider network that enhances collaboration among providers.
Case management is a core service, DD consumers need core services on going that are not identified in the plan. There is concern about funds being expanded on services of other populations that will not help meet needs of DD.	❖		Medium	See section entitled "DD Services" in the main document
There is a wide sentiment that area programs are not managed care entities, they are service providers. Area programs have the desire to provide services to the citizens of NC who have nowhere to go for treatment.	❖		High	LMEs will address in their local business plans how they will begin to function in their new roles as managers of services as set out in HB 381.
There is praise for the development of a mental health trust fund; there is not enough money in the system for all the proposed elements of the plan and to provide an adequate amount of quality services in each of the local communities.	❖		Low	The vision of the new system is one with stable funding.
There is concern that the secretary should mandate the development of a reasonable and fair decision making process among the divisions and this should be communicated to providers, consumers, and family members as department policy.	❖		Medium	See the main state plan document and the document entitled "Consumer and Family Involvement."
There is a concern that if the seven largest counties go it alone, it would seem the rest of the counties would	❖		Medium	See the section "Designing a New System for MH/DD/SAS" in the main document.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
be forced into one of a dozen or so managing entities that would span large geographic areas. This clearly seems to favor the notion of more local control.				
There is great deal of concern that the LME's should provide consumers and families with a comprehensive list of services available. Many consumers don't know the type of services available.	❖		Low	The plan calls for a public system that supports people with disabilities in making informed decisions. It supports a system that assists consumers and family members in becoming knowledgeable about the service delivery system.
Potential consumers need to be involved in the planning process even though it is difficult to access them.	❖		Medium	See section on consumers and family members, as well as the document entitled "Consumer and Family Involvement."
It is important to provide consumers and families with information about how to become involved in the local planning effort.	❖		High	See section on consumers and family members, as well as the document entitled "Consumer and Family Involvement."
Placing the LME's in an intermediary position between providers and the state would recreate the structural problems that have plagued the current system. At best, this approach would only build in unnecessary layers of duplicative and wasteful effort.	❖		Medium	The State Plan supports a new system free from unnecessary layers of duplicative and wasteful efforts.
A system such as this would require total cooperation from all parties involved.	❖		Low	See section on "Array of Services" in main document.
There is support for equitable rules across public and private sectors in the LBP.	❖		Medium	See section on "Infrastructure" in the main document.
The plan for uniform audit for public and private and a national accrediting process for all providers and LME's is a good idea.	❖		Low	See section on "Documentation" in the main document and the document entitled "Requirements of a Local Business Plan."
The business plan must detail how waiting lists and gaps in services, as well as critical services will be maintained, improved, or expanded.	❖		Low	See document entitled "Requirements of a Local Business Plan."
The LME needs to detail the services it anticipates to directly provide.	❖		Medium	See document entitled "Requirements of a Local Business Plan."

IMPLEMENTATON

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
For direct services, it is important to specify how and where case management services will be managed in order to achieve maximum consumer supports.	❖		High	See section on Core Functions in the main document.
An appropriate plan will review procedural issues such as emergency-disaster response in recovery as well as meeting the intended outcome.	❖		Medium	See section on "LMEs" in the main document and the document entitled "Requirements of a Local Business Plan."
LME must manage its budget contracts, payments individual budgets, and physical agents when reporting back to the state with required data processing.	❖		Low	See section on "Documentation" in the main document and the document entitled "Requirements of a Local Business Plan."
LME should insure how families, consumers, and stakeholders are to be involved in assuring quality performance by providers.	❖		High	See section on Uniform Portal in the main document and the document entitled Consumer and Family Involvement
The LME should complete self evaluation on its core management activities based on statewide outcome standards.	❖		Low	See section on LMEs in the main document, as well as the document entitled "Requirements of a Local Business Plan" and the Quality Management document.
The LME will detail how target populations will find access and use its services in order to live in the community.	❖		High	See document entitled "Requirements of a Local Business Plan"
It will be evaluated holistically as to whether it is family/consumer friendly.	❖		Low	See document entitled "Requirements of a Local Business Plan" and the Quality Management document.
Providers must maintain the right to determine who they are capable of serving.	❖		Medium	See section on Qualified Provider Network in the main state plan document.
IF the LME cannot provide a qualified provider then the LME itself is a logical provider until a more appropriate one can be developed.	❖		Low	See section on Qualified Provider Network. In the main state plan document.
The local business plan should describe how savings from consolidation and more efficient administrative functions, will be directed to increase the quality or quantity of MH/DD/SAS services for consumers.		*	Medium	Part of additional work to be added to the implementation plan.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
It is important that we be very careful to prevent the LME's from presenting themselves as the only reasonable choice to provide services, as that puts them into conflict with there duties to develop local private contractor capacity.	❖		Medium	See section on requirements of the LME in the main document and items within the implementation section.
The LME must describe ways in which minority populations will be reached and how services may need to differ based on cultural norms and values.	❖		Low	See section on qualified service provider and training in the main document.
There must be mechanisms in place to insure all new clients are enrolled by LME personnel in a timely fashion ie: seven working days from the first encounter.	❖		Medium	See section on LMEs and the document entitled "Requirements of a Local Business Plan."
As long as any entity controls access, management, and provides direct services, there is no competition.	❖		Medium	See section on Access in the main document and the document "Requirements of a Local Business Plan."
It is thought by some, that there is no incentive for an AP to want competition. There has to be a perceived benefit for AP's to want outsource services.	❖		Medium	See section on Access in the main document and the document "Requirements of a Local Business Plan."
The QMP document outlines a quality assurance/improvement/ monitoring system that is currently needed. The components of that system should exist at the provider and state level.	❖		Medium	See document entitled "Quality Management."
Centralization of quality monitoring does not necessarily constitute progress.	❖		Low	Centralization of monitoring, creates greater efficiency which constitutes progress
The possibility (opportunity) for subjective vs. objective judgement, and for poor or hard to measure criteria used to determine grades on a report cards is clearly in the system unless safeguard your place.	❖		Low	See document entitled "Quality Management."
Bench marks and trigger points must not encumber providers with additional expense unless those are clearly funded.	❖		Low	The state will establish trigger points, which support best practices and produce the desired effectiveness and efficiencies.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
LME report cards are good idea as long as they are open to the public and used for accountability issues.	❖		Medium	See section on "Report Cards" in the main document, as well as the document entitled "Quality Management."
It is the thought by some that providers will find incentives in filling "gaps" in area services, receiving a good report card which will create competition among providers.	❖		Medium	See section on "Report Cards" in the main document, as well as the document entitled "Quality Management."
There is a conflict of interest to provide services and provide UM.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document.
Some possible "benchmarks" include: Uniform Array of Services, Choice options for consumers available throughout the state.	❖		Medium	See section on infrastructure in the main document.
There is concern about complicated QA &QI procedures cost and sustainability.	❖		High	See document entitled "Quality Management."
Concern that uniform access does not meet principles of the plan.	❖		Low	Uniform portal does meet the principal of greater efficiency which is an important focus of the plan
We must place staff in the community to reach populations that may not want to be reached.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document.
LBP seems to be designed to maintain existing structure.	❖		Medium	Has been modified
Focus should be on designing supports and seeking provider responses to identify needs.	❖		Low	See section on Access, Target Populations and Array of Services in the main document.
Supports should be designed that keep people engaged in treatment.	❖		High	See "Sample Indicators and Quality Domains" in the main document.
Plan should address MHDDSAS services and supports related to all divisions not just those centered in MHDDSAS.	❖		High	Included in plan see main document
Information that providers are requested to track should be such that provisions may set clear improvement goals.	❖		Low	See section "Sample Indicators and Quality Domains" in the main document.

IMPLEMENTATON

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
Business Plan for LME should be concise in that the state parameters require a forward focus on operation. Minimum history requirements should be required, as the intent is to move the system towards legislative and departmental and consumer driven goals.	❖		Medium	See document entitled "Requirements of a Local Business Plan"
Involve consumers	❖		High	See recommendations in Chapter 4 and LBP
The section review process should allow for comment from consumer and advocacy groups. Widening the review team could broaden the burden or political issues surrounding not approving a plan.	❖		High	See section in main document, as well as in document in state plan series entitled "Consumer and Family Involvement"
We must get the Education establishment on board.		*	Low	Addressed in the system of care description in main document
AP's should provide needs assessment, case management state oversight.	❖		High	See section on LMEs in the main document.
AP's role as service provider should be limited.	❖		High	See section on LMEs in the main document.
Uniform access will decrease variability.	❖		Medium	See section on uniform portal. In the main document
There needs to be a point of responsibility for the client, and the uniform access process at the LME level has the potential to do that.	❖		Medium	See section on uniform portal. In the main document
Uniform access plan is short on details.	❖		Medium	See section on uniform portal. In the main document and document on "Requirements of a Local Business Plan."
When patient records are opened, how do we insure that privacy laws are respected?	❖		Medium	See section on documentation in the main state plan document.
LBP could be a good tool for accountability.	❖		High	See section on "System Quality Management Plan" in the main document.
Consolidation not only needs to take place fiscally and administratively, but also with regard to service consolidation and the transfer of responsibility for services to minimize service interruption.	❖		Medium	See section on implementation in the main document.

IMPLEMENTATON

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Implementation/State & Local Business Plan/LME's				
How is service gaps capacity and needs identified?	❖		High	See section on "Array of Services" in the main document.
More planning needs to occur concerning the types of services for what populations.		*	Low	A great deal of planning has taken place in regards to core services
Consider piloting the LBP concept in 1 or 2 AP's for a year or two to work out the kinks.		*	Low	Under consideration
AP's are stating that they will not fund ADVP programs because they are not listed in the State Plan. These services need to be included.	❖		Low	See section on requirements of LMEs and Core Functions
Establish a response system of accountability for LME's providers, and the state-with clear lines of authority.	❖		Medium	See section on "System Quality Management Plan" in the main document.
Can the proposed LME structure provide the core functions such that it is capable of achieving the outcomes as described?	❖		Medium	See section on "System Quality Management Plan" in the main document.
Plans that place a large number of citizens at risk because of regrouping services will not be approved, regardless of whether citizens are outside catchment area.	❖		Medium	See section on "Access and Target Populations" in the main document.

IMPLEMENTATON

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
Consumer transportation must be made available throughout the state in order for the system to serve all clients.	❖		Low	Added as a benefit
There is a recommendation to allow assessments and screenings without pre-certification from the UM entity.			Medium	The UM entity is one tool or access point into the service system. UM will operate as described in the local business plans of the LMEs.
System must insure that both voluntarily and involuntarily committed clients are transported with respect to safety and dignity.	❖		Low	See section on "Target Populations" in the main document.
Preliminary services for all disabilities could start at the point of entry, screening, assessment and referral.	❖		Medium	See section on "Access" in the main document.
How will funding be organized in a 3disability system?	❖		Low	Blending and funding has not been discussed as options other than for core functions.
Some services are expensive yet acute, others are considered permanent expenses.	❖		Low	See section on Array of Services in the main document
Cost data is needed when discussing core services.	❖		Low	See section on core functions and financing in the main document
There is a worry that core services will take up all resources, leaving very little money for target populations.	❖		High	See section on core functions and financing in the main document
Core services are basic and essential services that each local management entity must include in the Network. These services must be universally available.	❖		High	See section on core functions and the requirements of the LMEs in the main document
There are no guaranteed services for all, there should always be a screening to determine need and eligibility.	❖		Medium	See section on target populations, core services and financing in the main document
A logical structure should always be in place to access core services.	❖		Medium	See section on access and core functions in the main document
There is a need to show that the core services that are available have associated outcome measures.	❖		Medium	See section on "System Quality Management Plan"
It is acceptable to utilize uniform screening and	❖		Medium	See section on "Access and Uniform Portal"

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
assessment procedure.				
There is a need to reduce the core service benefit package.	❖		Low	Core Services benefits package was reduced from original presentation.
It would be easier to cost out core services if you consider them as the basic capacity of the Network for each local program.	❖		Low	See section on financing and Provider Network in the main document
We must insure high quality provision of service in both the public and private settings.	❖		High	See section on "System Quality Management Plan"
There has been inquiry as to what type of professional would perform the assessment for core services.	❖		Low	See section on Infrastructure in the main document
There was concern that the screening, assessment, referral function could end up being a holding tank.	❖		Medium	See section on access and core functions in the main document
The gaps in services serve as unknowns, there is a concern pertaining to what will happen while a person waits for the evaluation or referral process to be completed.	❖		Medium	See section on access and core functions in the main document
Gaps in treatment services can be minimized by trying to make sure that services are coordinated at all levels.	❖		High	See section on core functions and transitions in the main document
There was a belief that core services as they were presented, did not address the need of the target population.	❖		High	Core services meet the need of priority populations in a efficient manner
If cores services are more clearly defined and executed with greater practicality, they will address the need of the target population.	❖		Low	See section on access and core functions in the main document
There is a great deal of evidence, which proves that addiction treatment works and is cost effective.	❖		High	See section on substance abuse services in the main document
The system knows what to do and how to do it, the main issue is how to obtain the resources to save families, careers, and most importantly, lives.	❖		High	See section on access and core functions in the main document
There is a concern that any core services, including emergency services, that are made available to the	❖		High	See section on substance abuse services in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
entire addicted population would place a strain on the system, so that no resources would be left for addiction treatment.				

STATE PLAN FEEDBACK (second set)

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
We don't have cooperation among local agencies	❖		High	The plan underscores the need to develop and/or strengthen collaborative agreements.
As you're building consistent intake procedures, consider adding a family conference as a standard part of inpatient admission.	❖		Low	See section on access, core functions and array of services
This process is so standardized I am not sure it will serve the person (such as person-centered planning)	❖		Low	See section on access, core functions and array of services
Currently Licensed Professional Counselors cannot be reimbursed by Medicare, third party etc. ,will they be included in the access network?	❖		Medium	Addressed in Staff Competency document.
Suggestion for access is to include TTY # with 1-800 # . Standards, qualifications and licensure for interpreters and direct communication for deaf and English as a Second Language (ESL).	❖		Medium	Part of implementation plan.
Access is difficult for individual w/disabilities. Physical access to services is an issue.	❖		High	LMEs will address this in their local business plans.
Access assumes there is a system to access; in substance abuse there is no system to access. We must actually link people to services and that is access.	❖		High	The development of a continuum of care for substance abuse will need to be addressed by the LMEs in their local business plans.
This process does not work well for people w/cognitive disabilities. How does the access system interface w/choice and participant driven processes?	❖		Low	See section on "Designing a New System in the main document
Sounds as though people will self-identify; there needs to be a mechanism for outreach	❖		Medium	Outreach is a service of the LMEs.
When you talk about people receiving services and present at DSS or heath department, how will these other organizations staff be trained to recognize and assess the behavioral healthcare needs of their clients? Standardization: Who will be responsible coordination for access including forms?	❖		High	Cross-training and collaborative agreements will be important between agencies.

ACCESS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
What is "Interim treatment" and how will it be provided?	❖		High	If the ideal service is not immediately available for a member of a target population, then interim treatment will be offered as described in a local business plan as related on page 18 in the main document.
What will involving other agencies in the counties, what will that do to the single portal systems currently in place in many counties.	❖		Medium	Uniform portal is not meant to replace single portal systems currently in place in some counties, but will build on existing work.
Want to be sure there is choice of provider(s).	❖		High	Concept supported in plan.
Frequency and method to monitor implementation of plan (LME).	❖		High	Use of project management software will assist in monitoring the implementation plan
Concerned that services may be duplicated thereby increasing costs. (1)	❖		Medium	Addressed in local business plan.
Concerned that current AP structure may not be eligible for LME. Wants to make sure equal opportunities will be provided to continue serving people.	❖		Medium	The local business plan will address how the LME will support the principles outlined in the state plan.
Does everyone include indigent as well as insured?	❖		Low	Everybody is eligible to receive core services, but they may not need one or all core services.
As a private practitioner, am I to be on the network? These details must be operationalized.	❖		High	Private practitioners meeting professional standards as outlined in Division policy will be eligible to be on the network. This will be operationalized in time.
Does each LME establish standards? How is that different from what exists now?	❖		High	Standards will be consistent throughout the state.
Is it just getting name in the system or will there be a service in the community?	❖		Medium	Details to be operationalized during implementation.
How do you address individual services? This effort vs. regionalization?	❖		High	LMEs will address this in their local business plans.
LME is responsible for crisis. Where will money come from for 1-800 services? How will process work?	❖		High	Financial details are currently being finalized. The UM process is described under section entitled "Statewide System Contractor" and "System Access" in the main state plan document.

ACCESS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
Current service is working – Why create a new system? Has the plan considered what is working locally? The plan will take more people (Plan vs. HB 381). 1-800 + local response Issue of duplication – 24/7 phone after hours crisis.	❖		Medium	Comments, recommendations and feedback from consumers, family members, advocacy groups, statewide public forums and numerous studies of NC's MH/DD/SAS system indicate that the current service system has many problem issues that must be addressed. The plan attempts to build on best practices that are in place.
800 number directs people to slotted services, violates client choice and array of services for DD	❖		Low	UM supports participant-driven services and supports, along with a system that allows consumer choice.
Emergency not used in DD. This does not fit in with local emergency networking.	❖		High	Although DD may not access emergency services as frequently as other disability groups, emergency services will be available for DD consumers and/or family members if they need them.
Does it (800 number) preempt the use of local facility?	❖		Medium	UM can be by telephone and/or face to face.
Was study made on number of calls?	❖		Low	All relevant factor considered, research on best practice models supports this direction..
Must LME's use 800 Number?	❖		High	UM/800 number will be part of their local plan.
How accessible will 1-800 be for someone who is really in crisis? Will he/she get stuck on the phone waiting to talk with clinician for 30 minutes?	❖		High	Details of UM will be addressed in greater detail during implementation process.
800 number- How will the person covering know the resources other than to give phone number to call? How could you let people everywhere know of an 800 number? Would you publish phone number in every community? (which could be very expensive)	❖		High	Details of UM will be addressed in greater detail during implementation process.
Perhaps it would be helpful to identify the additional benefits of the 1-800 service that are not duplicated in the local emergency services.	❖		High	Details of UM will be addressed in greater detail during implementation process.
How can you insure that adding another access point (1-800) will simplify entry into system?	❖		High	Details of UM will be addressed in greater detail during implementation process.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
Staff at 1-800 number will likely be unfamiliar with local consumers. Does this not increase likelihood that fragmentation of care will occur?	❖		High	Service system must support implementation of Olmstead plan.
Timelines of receipt of services – clear timelines need to be set. How long can someone stay on a wait list?	❖		High	Service system must support implementation of Olmstead plan.
The people in the community which make those decisions as to how to prioritize the funds, what will be their training? What will make them eligible or knowledgeable enough to make these decisions? Will they try to provide enough money for all services thereby quality services will not be available?	❖		High	Technical assistance and training will be provided to communities.
When confronted by waiting list, you invite an escalation of the emergency admission.	❖		High	UM/800 number is designed to help decrease bottleneck into system.
How is this going to make things better?	❖		High	It will support mission, values and principles of new service system.
Will services be delivered to consumers in their homes to increase access for those who can't get to the services providers?	❖		High	Local business plans will address creative and innovative ways LMEs intend on providing services.
"Rotational" referral does not identify the most accessible provider geographically.	❖		Medium	Rotational referral would in fact be able to identify the most geographically appropriate
Drop-in centers and housing are identified as necessary for persons with SPMI. Every county in NC needs these – especially more housing but nothing is being done. How will this be done? Who will pay and who will decide how much housing etc will be available per county? Who and how ill prevention/education be provided to the public? Will funding be provided for this? Right now our Mental Health Association provides prevention and education services and we wish to continue these services. Not everyone wishes to use a mental health center. How do you propose to get people into the private system of care? And pay for the care for as long as needed?	❖		Medium	Description in target population of main document.

ACCESS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
What liability will the state face if people are "waiting" for an assessment and then "waiting" for a provider and program?	❖		High	See section on access and uniform portal in the main document
How will folks at VR, schools, DSS, etc get technical assistance, monitoring for consistency of information given re: access piece? What his their incentive to do this?	❖		High	Collaborative agreements and memorandum of understanding will support consistency of information. One incentive should be a shared client/consumer population.
Some persons with no insurance and limited discretionary funds will not meet target populations nor meet Medicaid eligibility. What happens to them when they are in need of services?	❖		High	Due to limited resources and finances these people will only be eligible for core services. LMEs may offer additional services as long as they don't prevent a member of a target population from receiving services.
As a former area program Crisis Manager I applaud the standardized plan across the state. I feel it is imperative that those staffing the referral 1-800 line be among our best Master's and Doctoral level clinicians. It will also be critical for those on the 800# to have a resource manual of services available in each LME as well as 24/7 access to local LME staff to receive referrals immediately without having to wait several days for an outpatient appointments at the local MHC.	❖		Low	See section on access and uniform portal in main document
A high priority population: those who lack insight into a severe mental illness. How will the state and local agencies interface with law enforcement to bring people into treatment? Will NC's Assisted Outpatient Commitment Law be utilized more broadly to help this highly vulnerable population and their families – and reduce risk of dangerousness in our communities?	❖		Medium	State Plan supports local efforts that enhance appropriate interface with law enforcement to bring people into treatment.
If someone can get an initial assessment and referral from "any public service agency," wouldn't this work best where those agencies are integrated. (I think	❖		Medium	Integration and seamlessness are supported in the principles and vision of the state plan in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
Wake & Mecklenburg counties are integrated) – Would this work better in such a service organizations?				
How will staff be trained to assist the individual? Assessment tools? Are individuals qualified?	❖		High	See section on training and staff competencies in both the main document and the document entitled "Staff Competencies, Training and Education"
If plan implemented as written – it will open avenues for access. Cross-training essential.	❖		High	See section on training in the main document and the document "Staff Competencies, Education and Training"
The suggestion was made to use technology for access, i.e. tele-braile, TTY for delivery- e.g. allow billing for telephone sessions.	❖		Low	Creativity and innovation are both important elements as the Division and the LMEs consider ways to enhance access through the use of technology.
Access services need to be delivered by staff who are disability Blind and competent. Local LME's should not be allowed to deliver services. The section should have detailed criteria and be required to meet with overseer form the state and reviewed annually land revoked immediately if LME does not meet criteria.	❖		Medium	See section on requirements of the LME in the main document
Access will improve if project like First in Families NC serve families that have not accessed the system. The idea of and Ultimate "safety net" fits the DD community with the tenets of the family support model & consumer –driven services where the family & consumer determine what is best for their needs.	❖		High	See section on DD Services in the main document
There are concerns of how the 800# will coordinate with the existing resource & referral phone services. 2-1-1 services are targeted to go statewide & probably nationwide in coming years. Will Intake services be included in the 800# to help the caller sort out among data bank options, or be give a list of all possible resources in their area. Could become over whelming.	❖		High	See section in the main document on assess and statewide contractor

ACCESS

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
Would the referring agency then be the Care/Case Management entity for the individual consumer/family? Does the idea of cross training multiple staff in multiple agencies not give way to some issues of clients being steered inappropriately to lover level services than needed due to that not being a primary function/role for those positions? In looking at coordinating services in a regional concept – what is happening to address transportation needs to access the services on a regional or local level? What are the payment paths for core services?	❖		High	See section on target populations and wrap-around services
What is in place to ensure the system of access is consumer-friendly? I.e., currently in the DD program, individuals are screened and referred. Then, every provider has its own screening process and the individual has to go through the same thing again. What happens when no privates want to serve an individual and the area program no longer has the infrastructure to serve?	❖		High	New service system is designed to be participant-driven and consumer-friendly. The specifics of the local plan will be specified in the LME's business plan.
Concern about just referral vs. some counseling involved- suggested need for counseling.	❖		Medium	See section on core functions in the main document
How are VR and DD involved and how is cost shared?	❖		Low	Additional information can be found in the DD document.
Where does Health Choice fit in regarding # of visits?	❖		Low	See section on "Department/Division Coordination and Infrastructure" in the main document
The DD service system has been driven by for-profit providers. If their profit margin is not satisfactory they will close providing services. (i.e. Charter Hospitals) When they cease service provision it will dismantle or drastically interrupt services for individuals with DD. We need to move into a more		*	Medium	This issue is currently being reviewed from several directions.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
balanced, reliable service system.				
Is there anything different than already exists- referral base doesn't necessarily improve existing services? Need more actual access and support to get to services, possibly services on site. The 800 number won't make much difference.	❖		Medium	See section on access and uniform portal in the main document
Case management level- how to deal with high case load.	❖		Medium	Consistency and uniformity in caseloads are addressed in main document and supported in the mission statement, vision and principles of the plan
Important to have 800 number be a real live person.	❖		High	See section on utilization management
Difficulty with getting to appropriate services in timely manner, especially when person in crisis (for example, suicidal).	❖		High	Emergency services are a core service available to everyone who needs them and call for 24/7, easy access, and in a timely manner.
Please ensure that those who want public facility care will not be denied access.	❖		Medium	See section on state facilities and transitions in the main document
Will there be ONE intake form across all agencies and ONE process?	❖		High	See section on access issues and uniform portal in the main document
Must retain sliding fee scale for those ineligible for Medicaid and continue to serve them as prevention	❖		Medium	See section on financing in the main document
Local not regional and larger	❖		Low	HB 381 calls for a reduction in the number of APs from 39 to less than 20.
Need increase of provider staff that can bill Medicaid.	❖		High	See section on "Qualified Provider Network and Direct Enrollment" in the main document
Any License professional staff should be able to bill Medicaid. Increase providers of staff that can bill. LPC, LCSW, License Therapist and SA Counselors. Medicaid (to be inclusive of all licensed mental health professions).	❖		High	Addressed in staff competencies
Concern as to access to crisis services in rural areas especially making face to face contact.	❖		High	LMEs must address these concerns in their local business plans.
Concern – access to psychiatric/therapist services – currently in Buncombe County, limited	❖		High	See section on "Qualified Provider Networks" and staff competencies in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ACCESS				
psychiatric/therapist services, this needs to be addressed.				
No one to transport consumers especially children provide therapeutic restraints. Need to fill this gap. Only one to do this is law enforcement (not appropriate).	❖		High	Transportation is a major issue that LME's must address in their local business plans.
If we regionalize, how will consumers obtain those services with limited resources such as transportation to the out of town service provider?	❖		High	Local business plans will have to offer such options as transportation assistance that is shared within geographic or catchment areas.
You mentioned some services may have to be regionalized. Clients in our rural area already have difficulty accessing services due to transportation, etc. How will they access services on a regional level?	❖		High	Local business plans will have to offer such options as transportation assistance that is shared within geographic or catchment areas.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
Names of populations are confusing. At risk child doesn't mean designated at risk by ARC. Need to distinguish what is "AT RISK". Law needs to be made clear what definition of populations that are to be used.	❖		Low	See section on Child Mental Health Services and Child Substance Abuse Services in the main document
DD target population same as what is currently served. Priority population continued to look at those folks who have most intense needs. Single portal – DD to change concern that needs a local clearinghouse to maintain a fair wait list.	❖		Medium	See section on target populations and uniform portal in the main document
Going to have a lot of children who can't access school because they don't meet target population and school says they can't come back if they don't get treatment.	❖		High	See section on target populations, core functions and wrap-around services in the main document
If there isn't enough money we will just be rearranging the waiting lists.	❖		High	See section on guiding principles and vision of the state plan, as well as the section on financing in the main document
Need to make sure we are assessing children as early as possible.	❖		High	EPSTD would be considered a core function in screening.
Pediatricians (EPSTD) need to be held more accountable in doing EPSTD's.	❖		High	EPSTD would be considered a core function in screening.
Does the draft Plan make clear who will get essential services in communities across the state?	❖		High	See section on access and core function, as well as target populations in the main document
One population that concerns me a bit is DWI offenders, as a taxpayer, are we paying for services to lawbreakers?	❖		Low	Description in disability chapter.
200% above poverty level should stay in plan.	❖		High	Based on current and projected finances, 200% poverty level for adult substance will not remain in target populations for substance abuse
Make sure there is some sort of standardization of decision trees to determine who actually has the right	❖		High	See section on target populations in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
combinations of signs and systems to fit into and be defined as a target population. Currently the descriptions of target populations appear pretty subjective				
Are we shifting responsibilities from the state to LMEs - who will NOT be served?	❖		High	See section on roles on the LME and target populations in the main document
Idea of target populations is in conflict w/idea of prevention in focus and consumer-driven process. Carves out people who are not seriously ill.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Substance Abuse target populations are federally funded; nothing will work until they get drunken males out of the hospitals and served in communities – unrealistic target populations – this is wacky.	❖		High	Implementation plan calls for addressing substance abusers that get sent to state hospitals by default.
Disconnect in Federal regulationss. For 18-21 year olds and target populations.		*	High	Cited as inconsistency in rule report
Middle people (not high intensity need) will not get served. This system sets up to serve people w/limited and high needs but not the middle.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Places undue burdens on local programs for low incidence groups. Suggestions – census of deaf people in state and state cooperation for SA/DD and deaf youth.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
We need to cover people w/co-occurring disabilities and specific tracking and funding for them.	❖		High	See section on "Co-occurring Disorders" in the main document
Child Mental Health – a set up for large waiting list	❖		Medium	See section on Child Mental Health and the Implementation Plan in the main document
If assessment indicates future needs, do we act now? Beyond the screening issue, get support before emergency need.	❖		Medium	See section on access and core functions in the main document
MR/MI needs to be addressed.	❖		High	See section on the implementation plan in the main document
Need for long term support for employment services. Other agencies/divisions must be coordinated and	❖		High	Supported in plan's vision and principles for consumers and should be described by LMEs in

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
brought into planning.				their local business plan.
Difference – rural and urban areas – not appreciated. Also, a large group of uninsured with mental illnesses will not be funded adequately.	❖		Medium	
What happens to those individuals that need services and are receiving services now but you decide no longer fits your target population?	❖		High	Suitable transition plans must be part of each LMEs local plan.
Who will provide services to these populations – LME's, private providers or either/and?	❖		High	
How do you define "most in need"? The plan to serve the most severe primarily is shorted. It proliferates an increase in severely ill population by reducing prevention.	❖		High	Includes diagnostic and functional elements, as well as strengths and risk factors and needs and circumstances.
There are concerns of availability of Early Intervention working with families at high risk for having children with developmental disabilities.	❖		Medium	
Currently there is a large percentage of the adult population being served that is neither SPMI or MI.	❖		Medium	Intent of target population to serve the most needy
If there are to be controls over the amount of services provided, there must be clear measurable criteria, which can be fairly and consistently implemented.	❖		High	Details of UM to be established. State will establish criteria.
It is going to be difficult to differentiate between urgent and critical as currently presented in the chart. There needs to be a scale to assist with this condition.	❖		High	Urgency grid is currently being further developed.
Concern of the current plan allowing for adult children who stay at home to get the same service that they would received in a state- run facility.	❖		Medium	
Spend money on consumers who benefit from the services. Re-consider spending money on existing services to SPMI etc. if Services are the same old thing.	❖			Reform realigns spending
Working poor seem lost in this plan.	❖		High	Dollars will be spent on target populations

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
TARGET POPULATION				
As it now stands, our county cannot identify and properly serve everyone with mh/dd/sa needs. How do you propose to try and serve/identify these people? This goes back to how, how, how. What is the incentive for serving effectively and how will be serve effectively?	❖		High	Should be addressed in the local business plans from the LME.
Sex offender population consumers frequently don't fit target populations (V codes) but are definitely in need of treatment. What happens to this population? What populations will not be serves?	❖		Low	DSM-IV diagnosis and co-occurring disorders. See target populations in main document.
People who don't get services right away might end up in the Target Population (even if they didn't at the beginning). Where is the prevention?	❖		High	See section on access and core functions in the main document
Economic and education system not sufficient	❖		High	See section on Designing a New System for MH/DD/SAS in the main document and the document entitled "Requirements for a Local Business Plan"
Target Populations too restrictive. What about the folks who are not the "most" severe.	❖		High	See section on access and core functions in the main document
Community clinicians are typically not interested in specialized MR/MH treatment, nor are they equipped to deal with crisis issues.	❖		Medium	See section on Designing a New System for MH/DD/SAS in the main document
In substance abuse those who want it must rather than those who someone think need it most will be a better use of these services….	❖		Low	See section on Substance Abuse Services in the main document and information on continuum of care
Alcoholics and addicts are not being identified in order to serve.!!	❖		High	See section on staff competencies, education and training

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ARRAY OF SERVICES / SERVICE GAPS				
CAP MR/DD: Need greater education to providers of services regarding equipment/DME? Process, letter of medical necessity requirements, augmentative communication devices. Providers such as OT, PT, SLP are not educated/informed about process	❖		High	See section on DD Services and staff competencies, education and training
There is no continuum of care for Substance Abuse.	❖		High	See information under "Duties and Functions of the LME" and details of the substance abuse services plan in the SA Chapter.
Concerned "array of services" is a slippery slope – families and consumers need to have control – this can be bureaucratically driven.	❖		High	See section of array of services and consumer and family involvement in the main document, as well as the document entitled "Consumer and Family Involvement"
Who is coordinating? Seamlessness of plan will not happen across providers.	❖		High	Addressed by the LME in their local business plan.
If Serving consumers in the community – Communities will have to develop resources.	❖		High	Supported in guiding principles and vision of the state plan
If services are to be cost effective, then we must develop viable services – There is an over emphasis on small.	❖		Medium	See section on "Duties and Functions of the LME" in the main document
Philosophy of participation of participant driven supports – Some misunderstanding re: control/cost effectiveness For Olmstead plans, there needs to be a community system in place.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Has state done studies about needed services? Preparing LME's to have an adequate responsive plan?	❖		Medium	Decision based on best practice models, research and consultant recommendations for North Carolina. See section on "Qualified Provider Networks" in the main document
Do not maintain a waiting list for DD services. Look at the states who have been being sued because of this issue. We must have a system in place to address getting rid of the wait list.	❖		High	See mission, vision and guiding principles in the state plan. Also, refer to implementation plan in the main document.
Nothing much available for people w/mental health.	❖		Low	See Adult Mental Health Chapter for specific details.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ARRAY OF SERVICES / SERVICE GAPS				
This is a dream. The only way providers will make a profit is to cut corners.				
Concerned there will not be enough services for recovering Substance abusers.	❖		High	See section on access, target populations and array of services in the main document
Health Delivery System needs to be better trained to identify substance abusers.	❖		High	See section on "Qualified Provider Network" in the main document and "Staff Competencies, Training and Education" document
Where is the state now in assisting us to develop the private provider network?? We are lacking in resources now so what makes the state think that we can do it per a "plan?" Has anyone tried to find a vacant bed recently in a PRTF?? 6 month waiting list. What about placement for a girl in Level III? The service array is pitiful in our state for persons with mental health issues, substance abuse, DD and we need help from the state in developing services – not mandating us to do it – will this show up on our report card?	❖		High	See section on "Qualified Provider Network and Direct Enrollment" in the main document
How will the needs of diverse cultures such as the Deaf culture, Spanish culture, Asian culture, etc. be assessed and treated?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document and the document entitled "Requirements for a Local Business Plan
It is expressed that a system be developed which does not allow a consumer to "age out" of their services.	❖		Medium	See section on the implementation plan in the main document
Dorothea Dix Hospital is a much-needed facility. It is suggested by some patients to build a new equivalent facility for acute care.	❖		High	See section on state facilities and the implementation plan in the main document
When we know that community supports represent best practice, why the heck (!!) are we proposing to open/develop a TBI unit at Black Mountain and specialized MR/MI units when we also know that some community providers have supported people with these diagnoses successfully? Why not use the	❖		Low	See section on "Designing a New System for MH/DD/SAS" and the "Implementation Plan" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ARRAY OF SERVICES / SERVICE GAPS				
successful providers as the model?				
Identification of providers for non-voluntary populations and most severe violent/disruptive children	❖		Medium	See section on Child Mental Health Services in the main document
We need separate system for DD population for many reasons: long term care, long term housing and Life Time Care, etc.	❖		Low	See section on DD Services in the main document
SPECIFIC TO DD The array of services section NEEDS to address substance abuse needs for individuals with DD. This is a major issue in that there are little to no service providers with expertise in the area of DD/SA and DD/MI/SA!	❖		High	Refer to section entitled "Co-occurring Disorders" in the main state plan document.
Will those living in the community be able to come into the institutions should they decide they want to go in?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
There seems to be a lack of understanding of the wide range of needs in each population, particularly those at the lower end of the functional bell curve.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Please keep Dorthea Dix Hospital and others open for the mental patients who need care and close supervision. Thanks!	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document and the implementation plan
There is great concerns about the welfare of children and how have they been cared for during any treatment of the parents with mental illness, and DD.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Add marriage and family therapy to list of array of services.	❖		Medium	See section on array of services in the main document
Don't forget DD aging out needs….hardly addressed. Not addressed in DD.	❖		Medium	See section on DD Services in the main document
Services for adult MI population seems to be more restricted than services to DD or SAS	❖		Medium	See section on DD Services in the main document
Who will be responsible for teaching private providers & other agencies where, when to send people to MH for access.	❖		High	See section on staff competencies, education and training and requirements and functions of the LME in the main document and in the stand along

ARRAY OF SERVICES

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
ARRAY OF SERVICES / SERVICE GAPS				
				documents
I didn't see ADAP's operated by MH center's will close? What if there is no ADAP in the county to provide the service once the area operated ADAP is closed.	❖		Low	Local business plan requirements.
There are aspects of the plan that are unrealistic in terms of current system linkages (e.g., across agencies, university affiliations)	❖		High	See the vision and guiding principles of the state plan and the section on "Designing a New System for MH/DD/SAS" in the main document
Array of services will require other agencies to cooperate but if their mandates are different. What is leverage to ensure other agencies do what needs to be dove to develop the services	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document and the document on "Requirements for a Local Business Plan"
Need list of services.	❖		High	See section on access, core functions and array of services in the main document
If LME cannot provide treatment to target populations, what will happen to treatment needs of people with MR/MI?	❖		High	See section on DD Services in the main document and the implementation plan
SUBSTANCE ABUSE SERVICES the Dept. of Corrections is the largest provider of substance abuse treatment in NC. Is the State Plan going to cover substance abuse treatment provided by Dept. of Corrections?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
If Area Programs can't provide services, does that render COA useless?	❖		Medium	See section on licensure and monitoring and the document entitled "Quality Management"
Outcome tools need a big look as to whether they are as objective as possible, measure progress/outcomes rather than status or how people feel/what they report	❖		High	See section on quality management and report cards in the main document
Outcome tools need a keen look – if they will be. Requiring LME to develop an array of services for their area will not make this happen. Outcome tools need a critical look – Need tools that better measure outcomes not status or perception/feeling about progress. COI –-listed as example – is very quick but a very inappropriate tool.	❖		High	See section on domains and quality indicators and the section on DD Services in the main document and the document on "Quality Management"
Need other standardized tool (other than AOI) to almost assessment of all populations.	❖		High	See section on domains and quality indicators and the section on DD Services in the main document and the document on "Quality Management"
What has been done i.e.: validating the info & benchmark noted on the AOI-	❖		Low	See section on domains and quality indicators and the section on DD Services in the main document and the document on "Quality Management"
Concerns about NC Snap as assessment tool.	❖		Medium	See section on domains and quality indicators and the section on DD Services in the main document and the document on "Quality Management"
Will private providers be held to competencies identified for API Division staff? Who will monitor their compliance?	❖		High	See section on LMEs in the main document
Unfunded mandates are no longer acceptable. The funding issue must be addressed for this to be a responsible plan.	❖		High	See section on financing in the main document and the implementation plan
Medicaid must cover in-home services to truly wrap services around children and families to implement the values and principles of new plan	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document

IMPLEMENTATON/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
Will the Division finally be restructured by service categories? i.e. housing, vocation/day treatment, community supports, psychological services	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
Where will the money come from to serve the new "community institutions"	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
We are going to have to have an adequate amount of funding per individual so there can be adequate training.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
The draft State Plan currently is a quite comprehensive and well planned document. As a provider agency, our responsibilities are acceptable and are presently part of our operations. As a part of the monetary process, would like to see intensive monitoring for deficient areas and technical support prior to immediate payback. All the LMEs to determine the plan of corrections with the monitoring component; failure to meet the plan of corrections will then result in monetary payback. With this plan, access will be easier for people to get services in my community.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
There is a disconnect with the local business plan – One must know what the LME will be prior to a business plan	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Enough public money – will money be available to meet needs?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document and the implementation plan
LME's not to provide services. 3 years then transition. Problem with small counties.	❖		Low	See section on the implementation plan, as well as refer to HB 381
Is there a state business plan costing out the plan? Will it happen? When: Yet LME's must provide money plan	❖		High	Cost modeling currently being considered.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
Need increase number of clinicians this may take care of target populations without limiting who gets served.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
LME's where will money come from for all these added responsibilities (monitoring, over-sight)	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
If LME provides services, have to have external care coordinator and QI/QA. If we can't find providers, where are we supposed to fine these people?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
If the LME establishes standards for their providers, how is that different than what happens now with area programs? As a provider, will I still contact with 7 (any number) different LME's hence, have to deal with 7 different sets of billing, documentation, etc..?	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document and the document entitled "Requirements for a Local Business Plan"
Must FUND services at levels needed	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Who provides quality services for the least amount of money? Who will be qualified in the LME to make such decisions? Will the state continue to monitor services or will the local (LME) govern this?	❖		High	See section on LMEs in the main document
Plan is dependent on other divisions/agencies to provide services. There needs to be coordination and planning to assure they can provide them.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document and the section on LMEs
Families and consumers left out on local quality improvement committee on p.184. Outcome measures – add ask consumers and families on p. 70	❖		Low	See section on family and consumer involvement in the main document, as well as the stand alone document
Has the Division EVER provided training on the GAF or CAFAS to area programs to get some "consistency" across the state? Will they provide it under the New Plan?	❖		Low	See section on Staff Competencies, Education and Training in the main document, as well as the stand alone document
There has been a reduction in patient services. Justification of this is necessary. What portion of	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
funds for the need services are developed by the communities?				
Staff Competencies – will wages be addressed in plan? Discusses turnover – but not specific wages. State that living wages will be paid.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Timelines proposed for re-org are totally unrealistic.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document and the implementation plan
FUNDING FOR PLAN – especially in rural areas	❖		High	See section on financing in the main document
Will there be consistent services from one end of the state to the other?	❖		High	See vision and guiding principles as well as array of services in the main document
Concern that it will be a real problem to have one county as a lead county in multi-county situation.	❖		Medium	See section on implementation plan, as well as refer to HB 381
Will the financial resources follow the array of services? (It must)	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document and the implementation plan
Definitions need to be clear and the same across the state and disability specific.	❖		High	See state plan glossary
Need clarification can a single county with less than 200,000 be an LME? (Very ambiguous).	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document, as well as HB 381
Need incentive for practitioners to go to rural areas to provide services.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Will money be available from the State? The public and private sector may not have these services.? Will there be an MIS system coordinating the needs /issues in all LME's?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document and the document on "Quality Management"
More sophisticated counties will be able to write better plan and get more funding.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
What assurances are there to make sure resources are distributed fairly on a per capita basis?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
Culture competencies should play a bigger role.	❖		High	See vision and guiding principles in state plan
Where will $ come from to serve the new "community institutions?"			Low	
Family and consumer input at the local level.	❖		High	See section on consumer and family involvement in the main document, as well as the document entitled "Consumer and Family Involvement"
I come from California where there was an attempt to shrink the number of beds in the hospitals in a push to improved community mental health. With CA hard financial times, the community mental health allocation of beds is now often filled by the criminal justice system. I.e., Will criminal justice systems take over vacant beds?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Will plans in all areas be standardized? Will individual needs, programs be addressed?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Communication of systems with each other to utilize state data – for planning or vendor purposes	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Psychiatric Nurses home services are to provide continued assessment and medical care.	❖		Low	See main document of state plan.
In an array of services, how will the consumers who need this service be served if there is not "enough" consumers that justify the operation of this service in my community?	❖		Medium	Interim treatment services could be provided.
State to do cost benefit analysis of increasing types of providers or Medicaid reimbursement. LPCs to be considered	❖		Medium	See section on staff competencies, education and training
Not clear about all the "System of Care" philosophy in Child Mental Health section relates to actual service/eligibility/funding policies of DSS & Medicaid. Not clear how "Community Collaboratives" can have decision-making authority	❖		Low	See section on Child Mental Health in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
legally vested in LMEs, DSSs, Juvenile Courts, Schools, etc. Mixing, blending & braiding" of funds does not happen in any of the current SOC sites and is wishful thinking. "Collaborative" is not a noun. (Check Webster's!) Private providers attempting to offer efficient, statewide services face dozens of contract and billing procedures created by local managing entities attempting to enforce standards and accountability. Nobody is helped by this complexity – it creates no accountability and detracts from real, value-producing quality management. Please standardize contracts, billing and documentation statewide! Better yet, use state-level contracting and enrollment.				
There are concerns of the accreditation function control and what will correct the current system of multiple requirements for providers who deal with several LME's.	❖		High	See section on licensure and monitoring in the main document
Who is the Local Management Entity? Is it Mental Health? Local county commissioners usually make these decisions i.e., funding. What do they know about providing services? Seriously!	❖		Medium	Additional information can be found in HB 381.
Community Capacity Building is currently being initiated by coalition in Wake County.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
Service Coordination should stay in the plan. First in Families is part of the coalition that could offer technical assistant to the rest of the state. Pg. 138 Screening, Assessment and Referral	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
With $47.5 million placed the trust to assist in implementation of this new plan's 38 area programs, increase in expense to cover services, how far do you	❖		High	Plan calls for cooperation between the Division/LMEs and DPI. Financing to be completed by 5-1-02.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
thing the funding will go? Are we trying to have other state class action cases such as Thomas S. and Willie M which has proved to be extremely costly? Who will be responsible for payment of the major advertisement of the 800 #'s? And will it be the same amount if funding to support it is issued by the Division? The plan clearly does not address how the new system will be funded. Once we have an idea of funding, we can then decide how to be creative with the resources.				
It was noted that if each MH/DD/SA group and experienced caregivers should have individual meeting these discussions would be fair and more effective.	❖		Low	See section on mission, vision, and guiding principles on the state plan, as well as section on consumer and family involvement
How many psycho-social clubhouses can be developed i.e. the Private Sector?	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document and the implementation plan
Provider network is great for some periodic services and in-home services, but it will fragment services for complex consumers: MD, Therapist, Case Managers, Psycho-socials, CBS etc. all in different agencies.	❖		Low	See section on "Qualified Provider Network" in the main document
Major concern that area programs will lose control over services offered and managed (e.g., in Mecklenberg Co.)	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
It is ridiculous to ask area programs to spend time writing a local business plan. It is not our plan. It is a state-directed plan, so let the state write and distribute it!	❖		Low	See section "Strategic Plan" in the main document and local business plan.
Please be direct about the intent of the plan – no opportunity for area programs to provide services.	❖		Medium	See section "Strategic Plan" in the main document and local business plan.
Good care will only be provided when staff are paid adequately enough to attract good professional staff.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
Presently staff are over-worked, under-paid, under-appreciated, high turnover and burned out.				
Conditions of work for front line non-supervisory staff should be addressed in an plan, such as living wage so don't need 2 jobs, adequate benefits and staffing ratios, staff seats on any body planning or overseeing services.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Don't see leadership of families in planning for developmental disabilities	❖		High	See section on consumer and family involvement in the main document, as well the section entitled "Consumer and Family Involvement"
More emphasis on text rather than outcomes for DD	❖			
Lack of coordination w/schools	❖		High	Plan calls for cooperation between the Division/LMEs and DPI.
Not enough time for a thoughtful review of the plan	❖		Medium	See section "Strategic Plan" and the "Implementation Plan" in the main document
The forum was set up such that it did not invite input (short time-frame to review, copies of the State plan were not accessible)	❖		Medium	See section "Strategic Plan" and the "Implementation Plan" in the main document
When local agencies don't want to cooperate- what then?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Plan good for 3 years- does that mean AP's hire temp staff just in case a service approved for 3 years is not approved for 3 more years.	❖		Low	See section on implementation plan in the main document
How can you reconcile a system that "meets the unique needs of each community" one that provides consistent service State-wide?	❖		High	See section "Strategic Plan" and the "Implementation Plan" in the main document and local business plan.
Need to address specifically how trigger points will work that then requires statewide UM.	❖		High	Issue needs to be further operationalized.
Trigger points sound easy. But the system must address how everyone determines that a recipient is at the trigger point. Without this, there will be utter	❖		High	See section "Strategic Plan" and the "Implementation Plan" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
chaos.				
Testing professionals/ paraprofessional is demeaning.	❖		Low	See section on staff competencies, education and training
It's a state driver plan, not a collaborative plan, The state will be the MH Center directly service out to communities. The community will be " Approved" to provide service via the plan.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document, as well as refer to HB 381
Page 133 references service brokers – under the title of "What it should look like", the plan makes reference to service brokers and what they do as " a task often performed by traditional case managers". Case managers are not service brokers and cannot just ""slide" into that position. Service brokering is a different job – clearly define that develop best practice training to ensure it occurs (on-going)	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
This forum was well orchestrated to ensure that real feedback would not occur? If you totally control what areas of the plan can be addressed, how can you have real input?	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
There need to be additional opportunities for input on this draft of the plan. It was very difficult to access for consumers and family members with adequate time to review. I am concerned that the plan does not specifically address funding or ways to increase use of federal or other non-state funding. Can plan include comprehensive funding strategy?	❖		Medium	Currently being addressed.
Page 134 of the draft plan: 2nd paragraph says "services and supports must meet…needs…..dictated by 2 person's disabling condition…" Services dictated by someone's disabling condition is the medical	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
model! We must begin with a p-c-p approach—establish what's important to the person and for the person. But don't begin with the disability!!				
I've heard that private Drs. don't want MH consumers from AP referred to them.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
What about the funding this will cost more to dismantle & restart than to make adjustments in a system that's already set up & functioning. doesn't need to be another unfunded mandate.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
What checks and balances are in place to ensure DHHS and DMHDDSAS will coordinate policy and planning efforts to eliminate conflicting standards, mandates and guidelines? It is difficult for LME to be accountable to conflicting standards, outcomes, ____ at, etc. Are LME's being asked to assume responsibility for direct enrolled and private providers over whom they have no authority!	❖		High	See section on "Strategic Plan" and "Designing a New System for MH/DD/SAS" in the main document
To develop a new UR/UM system adds one more layer to approval of services that may end up in conflict. (i.e.. New State System, LME, Medicaid UR, other Medicare UR, etc.). This will delay access to needed services.	❖		High	See section on access and uniform portal in the main document
There is an assumption that independent practitioners will jump in and fill the gap. Worried that we are throwing the baby out with the bath water. We have a system already and parts are good and it sounds like we want to throw it out and start over.	❖			See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
How will LME's be funded? Area programs are told to reduce administrative costs, yet the role of the LME is management not service ____administrative cost. Does the state and local plan ensure that funding will be available to care for all targeted clients? If not, what happens to them when the money runs out? Can an area program be a service provider? Who will fund cross-training among community agencies? Health Depts, DSS, etc. The assessment tool – who will be qualified to complete?	❖		High	Currently being developed.
The plan is a start- but has flaws- it has the unintended consequences of service disruption and dismantling -local determination/control is weakened -recommend a locally driven system	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Will local business plan and LME be maintained or managed like HMO's to the detriment of services, etc?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document, as well as the document entitled "Requirements for a Local Business Plan"
Is there going to be a limit control of how many folks each clinician can have?	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document, as well as the document entitled "Requirements for a Local Business Plan"
Please make sure on the advisory committee there are a full range of mental health professionals – include all master's level providers – LCSW, Licensed marriage and family therapists as well as psychiatrists & psychologists Please make sure all Master's level licensed mental health professionals be treated equitably – Licensed marriage and family therapists who have MA's or PhD's and extensive training in working with	❖		Medium	See section on staff competencies, education and training

IMPLEMENTATON/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
individuals, families, and children are now often excluded from agency employment. Please make sure this inequity is addressed. LMFT's should be treated equitably with LCSW's – both are Master's Level licenses with extensive education, training and licensing requirements. There are not 2 MFT training programs in NC.				
Does plan require local funding or all form state – shared obligation between state and local ?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document, as well as functions and duties of the LME
May be populations we can no longer serve, might require other funding than state.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document, as well as the document entitled "Requirements for a Local Business Plan"
Can we count on the money?	❖			See section on "Strategic Plan" and "Designing a New System for MH/DD/SAS" in the main document
How will dollars get allocated in terms of target population – how to determine numbers in a fair and equitable manner? How to insure target populations or core services don't take all the money.	❖		High	See section on "Strategic Plan" and "Designing a New System" for MH/DD/SAS" in the main document
There are many statements in the plan that are assumptions, not backed up by data, and in some cases incorrect all together.	❖		Low	See section on "Strategic Plan" and "Designing a New System for MH/DD/SAS" in the main document
We do not have private providers beating down the doors of Area Programs to serve the most needy consumers in MI/DD and substance abuse.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Will track records of AP as providers of services be considered in allowing them to continue providing services? May have private providers, but their standards for quality are questionable- lots of	❖		High	See section on "Qualified Provider Networks" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
IMPLEMENTATION/STATE & LOCAL ADMINISTRATION/LOCAL BUSINESS PLAN/LMEs				
problems that never get addressed by state.				
Competency system focuses on service providers not administrators- what do we need to expect from supervisors and administrators?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
When does care get critical for the children first? Is this an area authority 1 LME function? Will this be formed out along with other services?	❖		Low	See section on functions and duties of the LME in the main document and local business plan.
Local Business Plan concerns: counties won't and cities may; why would they? 5 counties or 200 K pop. Inequity of funding statewide? Get it fair.	❖		High	Addressed in the local business plan document.
Does the Division plan to become an MBHO (managed behavioral health org) and then get NC QA accreditation?	❖		High	The plan addresses the roles and responsibilities of both the state and the Division.

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
Where is the expectation of payment for services for people who do not fall in the "Target Population" but still need services?	❖		Medium	See section on access, core functions and array of services in the main document
Better control and management for OT, PT Speech (for children) UM like MH.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
Cost for people for medication when they exceed more than 6 per month.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
Concerned that core services are not typically used by DD population thereby using up money that DD needs.	❖		High	See section on access, uniform portal and core functions in the main document
Add treatment	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Serving people within their community. No home address, no place to live falls between cracks. Which community will serve? Will not having an address be a block to services?	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
If someone chose outside their community, will that be permissible?	❖		Low	See section on "Strategic Plan" and "Designing a New System for MH/DD/SAS" in the main document
800 Number qualified staff	❖		High	See section on statewide system contractor in the main document
LME – Authorization agent – UM management authorization……conflict?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Money proportioned/divided among disability groups – not spent by one disability	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Dumping vs. local services, issue of receiving what is needed in the community. Who assumes risk?….state….LME	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Administrative costs will decrease? The plan talked about staff turnover being a problem especially for case managers. How can we realistically lower these costs and hire high quality certified staff to contract/work for programs?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
Funds run our quickly. Prevention works but cannot fully fund services now. If treatment is not a core service, children with mild difficulties are the last target. Local communities are set up to fail the children who will not likely benefit from short -term services.				
Service coordination is defined as an administrative function in the plan. This person represents the "system". Need to add another core service that represents the consumer in planning budget process. This service would not be connected to the funding source.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
Concern about private providers. Some are good. They are more concerned about making money for the owners than providing quality services including qualified staff (having enough) to meet individual needs. I work for a state system and even we don't have enough staff.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
Need to address how to entice service providers to provide services to target/priority population.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
System issue, need increase number of psychiatrists to provide services especially in small county/area programs where have one Psychiatrist two times a week. Need to consider with use of nurse practitioners and clinical nurse specialist and being able to bill assessments	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document and local business plan, education/training document.
We need to keep our eyes on the long term and not exhaust all resources too early.	❖		High	See section on "Strategic Plan" and "Designing a New System for MH/DD/SAS" in the main document
Now we are not going to do away with our institutions are we?	❖		High	See section on "Designing a New System for MH/DD/SAS" and the implementation plan in the main document
There will always be a need for institutional care. Will	❖		Medium	See section on "Designing a New System for

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
those who want to remain in an institution, be able to do so?				MH/DD/SAS" in the main document
Can you explain service coordination? Is that a new LME function and will there be a way for the LME to get paid for performing the function?	❖		Medium	See section on access and core functions in the main document
Given previous complaints about de-institutionalized consumers creating threat to families and caregivers who are denied local services...are we going to just be repeating that same mistake again? This plan is going to take a lot more money if it is to function in a way that actually supports community based behavioral healthcare.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Is this plan really going to do what it says it is going to do?	❖		High	See section on "Strategic Plan" and "Designing a New System for MH/DD/SAS" in the main document
MH visits will be limited? This is a concern for adults. Will there be more visits?	❖		Medium	See target populations in the main document
Define what core services are? Leave out treatment in real rural areas – no private providers. Not enough money to keep private providers in business LME will have to provide this.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Want to make sure to have treatment for target population.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Concern about currently serving folks who do not fit the target populations. What will happen to these folks? How to step down?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Expectation that there will be volunteer organizations to take referrals of person not in a targeted population, have no insurance or funds to pay needs to be addressed. They will not receive services.	❖		Medium	See section on access, core functions and array of services in the main document
If de-institutionalization takes place – will there be services and supports in the community? There is an under-funding now – how correct?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
Following individuals into the community – How? What supports?				
Are we going to have to downsize support staff because not enough core services are being provided at the "central" office?	❖		Medium	See section on "Strategic Plan" and "Designing a New System for MH/DD/SAS" in the main document
Deaf and hard of hearing or Deaf and developmentally disabled – are unable to access services sometimes – need to make sure people w/multiple disabilities can access community services.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
We don't provide training for police but that is the way many will access services.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Concern that emergency triage means that some people will be "written off". Are we sure we want to use the word "triage"?	❖		Low	See HB 381
Suggest that we include on-going psychiatric services in cases where there is no willing or available provider.	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
Things that we are not currently funding are listed – we need to make sure we can fund.	❖		High	See section on "Designing a New System for MH/DD/SAS" and the implementation plan in the main document
Would core services not include therapy/medication?	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Concern about whether there will be anything left for LME to manage. There is a disconnect w/the person because management of the service is not local but being contracted to a single contractor.	❖		High	See section on functions and duties of the LME in the main document
Need to broaden the definition of prevention to look at causal factors such as poverty, disenfranchizement, bigotry, social injustice. Posters, billboards & MH Fairs is NOT comprehensive	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Why are people misconceptualizing the prevention core function process? Prevention is on the spectrum of care. We are implementing research-based programs that have been proven to reach effective	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
CORE FUNCTIONS				
outcomes by _____process and planning. Prevention is cost effective. If we can ___ ___, then we can look at other target populations.				
We need to assure that treatment is part of this for the most seriously ill clients will not be treated by private providers. They refuse treatment to those clients.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
How did treatment get eliminated as a core services?	❖		Medium	See core functions in the main document and the HB 381
If referral is core service and client is not in target population and is indigent – where will the referral be? Who will pay? Cane we realistically expect "faith community" to carry these clients? How can we expect LME to coax quality providers to do whole-scale free care?	❖		High	See section on access, uniform portal and core functions in the main document
Not enough providers accepting Medicaid- need explanation of what LME is providing more than the "Core".	❖		High	See section on LME in the main document
Follow-up for individuals referred out needs to occur.	❖		High	See section on access and uniform portal in the main document
Core is like an entitlement – could these core services "bust" the system, especially with the inclusion of crisis services.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Change "Core" to "Initial" or "Primary"	❖		Low	See HB 381
Plan should allow for flexibility of funding to allow for planning to meet unique individual needs.	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document
Where do developmental technicians and front line workers fit- who are overworked and underpaid. Communication issues from them to upper management and vice versa. What do assessments include, and how do you best utilize these line staff?	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document, as well as staff competencies, education and training
Core services cannot be effectively separated out from intervention due to relationships between DSS, DJJ, and schools	❖		Medium	See section on "Designing a New System for MH/DD/SAS" in the main document

STATE PLAN FEEDBACK

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
Material presented on Target Populations by DD, was consistent with Arc.	❖		Low	See section on target populations and DD Services in the main document
Conflict of interest associated should be developed centering on service management and provision.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Information that providers are requested to track should be such that provisions may set clear improvement goals.	❖		Medium	See section "Quality Management" in the main document
Report cards should enable consumers to utilize information to evaluate which service or provider is most effective in meeting the needs of the consumer.	❖		Medium	See section on "Report Cards" in the main document
Their needs to be more said about competition and consumer choice.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
Until we have better technology, we need to do outcomes like those on the COI for persons with MI	❖		Low	See section on "Designing a New System for MH/DD/SAS" in the main document
We must insure high quality provision of service in both the public and private settings.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
There has been inquiry as to what type of professional would perform the assessment for core services.	❖		High	See section on access, uniform portal and statewide contractor in the main document
There was concern that the screening, assessment, referral function could end up being a holding tank.	❖		Medium	See section on access, uniform portal and statewide contractor in the main document
If cores services are more clearly defined and executed with greater practicality, they will address the need of the target population.	❖		Medium	See section on access, uniform portal and statewide contractor in the main document
There is a great deal of evidence, which proves that addiction treatment works	❖		High	See section on vision and guiding principles and the section on "Designing a New System for MH/DD/SAS" in the main

FEEDBACK	Covered in plan	Not covered in plan	FREQUENCY High/Med/Low	COMMENTS
and is cost effective.				document
The system knows what to do and how to do it, the main issue is how to obtain the resources to save families, careers, and most importantly, lives.	❖		High	See section on "Designing a New System for MH/DD/SAS" in the main document
There is a concern that any core services, including emergency services, that are made available to the entire addicted population would place a strain on the system, so that no resources would be left for addiction treatment.	❖		High	See section on target populations in the main document